





# American Hospital Association

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DATE: February 1, 1965  
TO: Members of the Society of Medical Administrators  
FROM: Vane M. Hoge, M.D.  
SUBJECT: The DeBakey Report and H.R. 1

At the meeting of the Society last month, I promised to send all the members a copy of the DeBakey report and a copy of H.R. 1, The Hospital Insurance, Social Security, and Public Assistance Amendments of 1965.

I have since learned that copies of the DeBakey report are being sent to all hospitals and all physicians registered in the American Medical Association directory. This should mean that everyone of our group should get at least one and maybe two copies, which should make an additional mailing unnecessary. If within a reasonable length of time any one should not have received a copy of the report, please let me know.

Copies of the full bill H.R. 1 are not obtainable in sufficient numbers for a complete mailing. Instead we are sending you the enclosed abstract of the bill as prepared by the Department of Health, Education, and Welfare.

Please feel free to let me know of any additional materials you may wish in connection with this or other pertinent legislation.

ahp

enclosure 1

## Description of "Hospital Insurance Act of 1965"

### PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

The bill specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided and the administration or operation of medical facilities.

### FREE CHOICE BY PATIENT GUARANTEED

The bill specifically provides that a beneficiary may receive services from any participating provider of his own choice.

### ELIGIBILITY

The proposal is limited to coverage of the aged because the aged as a group have low incomes and high medical care expenses. Moreover, they are at a period in life where their incomes and assets are more likely to go down than up. Their income is, on the average, about half that of those under 65; at the same time they require three times the hospital care of younger people. Furthermore, since most aged people are not employed they have in general no opportunity to obtain economical group insurance. The individual or nongroup health insurance that may be available to them is about 1 1/2 times as expensive for the same benefits--because of higher acquisition cost, premium collection cost, and other administrative costs--as group insurance would be.

Under the bill, hospital insurance protection would be provided for all people who are aged 65 and over and entitled to monthly old-age or survivors insurance benefits or to benefits under the Railroad Retirement Act. An individual would be eligible for hospital insurance protection at age 65 even though his monthly cash benefits are being withheld because of earnings from work. In addition, protection would be provided, under a special provision of the plan, to many people aged 65 and over who are not eligible for benefits under the social security or railroad retirement systems.

Almost all of the people who will be age 65 and over in July 1966 would be protected under the proposal. The few not protected under the legislation would consist for the most part of retired Federal civilian employees, who have their own health insurance program, and aliens with relatively short residence in the United States. Of the

people protected under the proposal, about 16 2/3 million would be covered as persons eligible under the old-age and survivors insurance or railroad retirement programs and about 2 million would be protected under the special provision.

Under the special provision, aged people who are not insured for cash benefits under the social security or railroad retirement systems would be deemed insured for hospital and related benefits only. Uninsured people who reach age 65 in 1968 would be deemed to be insured for hospital benefits if they had earned as few as 6 quarters of coverage in covered work at any time--11 fewer quarters of coverage than men of this age need to qualify for cash social security benefits.

For people who reach age 65 in each of the succeeding years, the number of quarters of coverage needed to be insured for hospital insurance protection would increase by 3 each year. Thus the provision would not apply to women who reach age 65 in 1972 (or later) and men who reach age 65 in 1974 (or later), since in those years the number of quarters that would be required to qualify for hospital benefits would be the same or greater than the number required for social security cash benefits.

The cost of the coverage for aged persons who do not meet the regular insured status requirement of the social security law would be met from general revenues. Thus, the provision of the same hospital benefits for persons who are not fully insured under the social security system would not be inconsistent with the principles upon which the system is based. Funds obtained through the application of social security contributions would be used only to pay benefits of those who have contributed over a sufficient length of time to acquire insured status, and over the long run only persons who make significant contributions would be eligible for benefits.

#### BENEFITS PROVIDED

The bill would provide payments for inpatient hospital services, follow-up care in an extended care facility, certain organized home health agency services and outpatient hospital diagnostic services.

Inpatient hospital services were selected as the point of concentration in the bill because of the great financial strain placed on people who must go to the hospital. Medical expenses for aged people who are hospitalized in a year are about five times greater than the annual medical bills of aged people who are not hospitalized, and hospital costs account for the major portion of the difference between the health bills of the hospitalized aged and those not hospitalized. Further, the occurrence of hospitalization one or more times in old age is to be expected. It is estimated that nine

out of every ten people who reach age 65 will be hospitalized at least once before they die; two out of three will be hospitalized two or more times. Another reason for placing primary emphasis on protection against the cost of hospital care is that hospital insurance is the part of the protection against health costs on which there is the most experience in this country--through Blue Cross and other Government programs--with the result that adequate models for administration are available.

## SERVICES FOR WHICH PAYMENT WOULD BE MADE

### Hospital Services

The proposed inpatient hospital benefits would (except for the deductible amount) generally cover the full cost of all hospital services and supplies of the kind ordinarily furnished by the hospital which are necessary in the care and treatment of its patients. Up to 60 days of hospital care would be covered. The full coverage of hospital costs follows the recommendations of expert groups studying hospital insurance. As hospitals acquire new equipment, adopt new health practices, and improve their services and techniques, the additional operating costs resulting from such changes would automatically be covered under the proposal without need for modification. Thus, coverage would always be up-to-date. Furthermore, this built-in responsiveness to changing medical practices and needs would provide assurance that the program would provide the proper financial underpinning to improvements in care.

### Post-Hospital Extended Care

The bill would provide payments for the cost of post-hospital extended care (in a facility having an arrangement with a hospital for timely transfer of patients and medical information about patients) in cases where a hospital inpatient is transferred to such a facility to continue to receive professionally-supervised convalescent and rehabilitative care (while under the care of a physician) needed in connection with a condition for which he had been hospitalized. The requirement that the patient have been transferred from a hospital is one of the measures included in the bill to limit the payment of extended care benefits to persons for whom such care may reasonably be presumed to be the most logical medical step following intensive inpatient hospital care.

### Home Health Care Services

Payments would be made for visiting nurse services and for other related home health services when furnished by a public or nonprofit agency in accordance with a plan for the patient's care that is

established and periodically reviewed by a physician. Since the nature and extent of the care a patient would receive would be planned by a physician, medical supervision of the home health services furnished by paramedical personnel--such as nurses or physical therapists--would be assured.

#### Outpatient Diagnostic Services

In the case of outpatient hospital diagnostic services, payment could generally be made for any tests and related services that are customarily furnished by a hospital to its outpatients for the purpose of diagnostic study. Payment would only be made for the more expensive diagnostic procedures because a deductible amount (equal to one-half the deductible amount for inpatient hospital services) would be applied for each 30-day period during which diagnostic services are furnished.

#### Patient's Need and Economy Served

The bill provides payments for post-hospital extended care, home health agency services and outpatient hospital diagnostic studies in order to promote the economical use of hospital inpatient services. In doing so, the proposed legislation would support the efforts of the health professions to limit the use of hospital beds to the acutely ill who need intensive care and to make more efficient use of other health care facilities. Moreover, coverage of these services is consistent with the recommendations made by authorities who have studied the causes and effects of improper utilization of hospital care. For example, the availability of protection against the costs of outpatient hospital diagnostic tests would avoid providing an incentive to use inpatient hospital services in order to obtain coverage of the cost of diagnostic services. The availability of this protection would also give support to preventive medicine by meeting part of the costs of expensive procedures that are essential in the early detection of disease.

### INCLUDED AND EXCLUDED SERVICES

Under the bill, payment would be limited to health services which are essential elements of the services provided by hospitals. Since the primary purpose of the proposal is to cover hospital costs and a major reason for the coverage of other services is to provide economical substitutes for hospitalization, the proposed legislation is framed to permit payment for post-hospital extended care, home health, and outpatient hospital diagnostic services only to the extent that they could be paid for if furnished to a hospital inpatient. Thus the outer limits on what the proposed program

would pay for are set by the scope of inpatient hospital services for which payment could be made. Services covered outside the hospital are more limited than those in the hospital. Following is a description of the various services for which payment would be made under the bill.

### Room and Board

Payments would be made for room and board in hospital and extended care facility accommodations. Generally speaking, accommodations for which payment would be made would consist of rooms containing from two to four beds. Covered accommodations are described by number of beds, rather than the frequently used designation of "semiprivate." The differences that exist among hospitals in the use of the term "semiprivate" would create an undesirable lack of uniformity of benefits provided if that term were used.

Payments could also be made for more expensive accommodations where their use is medically indicated. Where private accommodations are furnished at the patient's request, the payments that would be made would be the equivalent of the reasonable cost of accommodations containing two to four beds. Room and board would not, of course, be paid for where the beneficiary is receiving care under a home health plan.

### Nursing Services

Payments would cover all hospital nursing costs, but not private duty nursing. Private duty nursing would not be paid for since it can be expected that the nursing services regularly provided by hospitals and extended care facilities which would participate in the program would almost always adequately meet the nursing needs of their patients.

Payments for home health services would only cover part-time or intermittent nursing care such as that provided by visiting nurses. Where more or less continuing skilled nursing care is needed, an institutional setting is more economical and generally more suitable.

### Physicians' Services

The cost of physicians' services would not be paid for under the proposal except for the services of hospital interns and residents-in-training, and for the professional component of certain specified ancillary hospital services described below under "Other Health Services."

The bill would cover the cost of the services that hospital interns and residents-in-training furnish but only while they are participants in teaching programs that are approved by the American Medical Association's Council on Medical Education and Hospitals or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. This coverage of the services of interns and residents is in agreement with the generally accepted principle of hospital payment that third parties should contribute a fair



share toward the hospital costs--in large part consisting of educational costs--of interns and residents.

### Drugs

Under the bill, payment could be made for drugs furnished to hospital and extended care facility patients for their use while inpatients. The bill would provide payment for drugs which are approved by the hospital's pharmacy committee (or its equivalent) or which are listed in the United States Pharmacopoeia, National Formulary, New Drugs, or Accepted Dental Remedies. A hospital's drugs must, of course, meet the standards established by these formularies in order for the hospital to be accredited by the Joint Commission on Accreditation.

The drugs prescribed for a patient as part of his home health care would not be paid for under the proposed program. The decision to exclude the cost of drugs from home health service payments is part of the more basic decision not to provide coverage of drug and other outpatient therapeutic costs under the program. The coverage of drugs outside the institutional setting would, of course, add greatly to the cost of the program and would present exceedingly difficult problems in limiting payment to needed drugs and covering the payment of a multitude of small bills without excessively cumbersome and expensive administration.

### Supplies and Appliances

Under the proposal, payment would be made for supplies and appliances so long as they are a necessary part of the covered health services a patient receives. For example, the use of a wheelchair, crutches or prosthetic appliances could be paid for as part of hospital, extended care facility or home health services but payments would not be made for the patient's use of these items upon discharge from the institution or upon completion of the home health plan. Extra items, supplied at the request of the patient for his convenience, such as telephones in hospitals, would not be paid for.

### Medical Social Services

Payments would cover the cost of the medical social services customarily furnished in a hospital, as well as such services furnished in an extended care facility or as part of a home health plan. Such services often perform the important function for the aged of facilitating a return to normal life at home.

### Other Health Services

Payment would be made for the various ancillary services customarily furnished as a part of hospital care, including various laboratory services and X-ray services and use of hospital equipment and personnel. Among the covered services would also be physical, occupational, and speech therapy. Payment for ancillary services would cover the costs of services rendered by physicians in four

specialty fields--anesthesiology, radiology, pathology and physiatry--where the physician furnishes his services to an inpatient as an employee of the hospital or where he furnishes them under an arrangement with the hospital which specifies that payment to the hospital for the services he performs discharges all liability for payment for the services. Thus, whether the services of any particular specialist are covered would depend entirely upon the arrangement between the physician and the hospital. The chart below lists the specific kinds of hospital and related care for which payments could be made and those which would not be covered.

### LIMITATIONS ON PAYMENT

The bill includes a number of limitations on the payment of hospital and related benefits, primarily because of considerations of cost and priorities of need.

The deductible provision and the other limitations on inpatient hospital and post-hospital extended care payments would be applied on a "benefit period" basis. In general, the "benefit period" would coincide with the beneficiary's episode of illness. Under the proposal, the benefit period would begin with the first day in which the patient receives inpatient hospital services for which payments could be made and would end after the close of a 90-day period during which he was neither an inpatient in a hospital nor an extended care facility; the 90 days need not be consecutive, but they must fall within a period of not more than 180 consecutive days. This limitation is designed to provide a cut-off point in the payment of benefits for persons who are more or less continuously institutionalized persons without, however, denying payment for persons who suffer repeated episodes of serious illness.

#### Duration of Benefits

Inpatient hospital care for as many as 60 days during a benefit period would be covered under the proposal. A maximum of 60 days of post-hospital extended care is provided for each benefit period.

Under the proposal, as many as 240 home health visits could be paid for in a calendar year. The limitation placed on the payment of home health benefits is written in terms of "visits" rather than "days." Unlike the institutionalized patient, people receiving home health services do not receive health care on a full-time basis. Home health services involve periodic visits to the patient's home by therapists, nurses, and other professional personnel. The amount of home health service which is covered would be unaffected by whether a variety of services is offered on the same day or different days.

# HEALTH SERVICES AND SUPPLIES THAT COULD BE PAID FOR UNDER THE HOSPITAL INSURANCE ACT OF 1965

	Inpatient hospital benefits	Post-hospital extended care benefits	Outpatient hospital diagnostic benefits	Home health agency benefits
Room and board	Coverage limited to bed and board in a 2-4 bed room or in more expensive accommodations where medically required		Not applicable	Not covered
General duty nursing services	Covered (benefits would not cover private duty nursing)		Not applicable	Coverage limited to part-time or intermittent nursing care
Physicians' services	Not covered except where furnished by an intern or resident-in-training in the course of a teaching program approved by the AMA or, in the case of an osteopathic hospital, by the AOA, or where the services are in the field of pathology, radiology, anesthesiology, and physical medicine and are rendered through the hospital. Services furnished in an extended care facility by interns and residents-in-training under an AMA or AOA approved teaching program of the hospital with which the facility has an arrangement for timely transfer of patients would be covered.			Not covered except where furnished by an intern or resident in the course of an AMA or AOA approved hospital teaching program.
Physical, occupational, and speech therapy	Covered		Not applicable	Covered
Medical social services	Covered		Not applicable	Covered
Drugs	Covered		Not applicable (except as needed for diagnostic study)	Not covered
Other services and supplies necessary to the health of the patient	Covered if the hospital customarily furnishes them to its patients	Covered if generally provided by extended care facilities	Covered if customarily furnished by the hospital to outpatients for the purpose of diagnostic study	Medical supplies (other than drugs) and the use of appliances are covered. Also, to the extent permitted by regulations, part-time or intermittent services of a home health aid would be covered

### Deductible Provisions

Payment for inpatient hospital services during a benefit period would be subject to a deductible amount equal to the average cost of a day of hospital care.

A deductible of one-half this amount would be applied against payments for diagnostic services furnished within a 30-day period primarily to reduce costs and to avoid processing a large volume of small claims. Thus the program provides protection against the cost of the more expensive procedures--not only the single expensive test but the series of tests in which costs add up to large amounts.

### CONDITIONS FOR PARTICIPATION OF PROVIDERS OF HEALTH SERVICES

One of the keys to determining the nature of the health services which would be paid for under the proposal is the type of institution which may participate in the program. Therefore, the question as to what, for purposes of the proposed program, is a hospital, an extended care facility, or a home health agency is of considerable significance. There are no universally accepted definitions of the various health facilities. The type of institution providing health services on which there is closest agreement on definition is, of course, the hospital. The definition of a health institution includes within it elements related to the quality and adequacy of the services which the institution provides. For example, one of the conditions an institution must meet to satisfy the American Hospital Association requirements for listing as a hospital--the same condition which would have to be met before an institution could participate under the program--is provision of 24-hour nursing service rendered or supervised by registered professional nurses. This is one of the characteristics that differentiates a hospital from other institutions; in addition, of course, an institution which does not meet this condition cannot offer adequate services as a hospital.

The bill therefore spells out the conditions that an institution must meet in order to participate in the program. These conditions offer some assurance that participating institutions have the facilities necessary for the provision of adequate care. Also the inclusion of these conditions is a precautionary measure designed to prevent the program from having the effect of undercutting the efforts of the various professional accrediting organizations sponsored by the medical and hospital associations, Blue Cross plans, and State agencies to improve the quality of care in hospitals and other health care facilities. To provide payments to institutions for services of quality lower than are now generally acceptable might provide an incentive to create low quality institutions as well as an inducement for existing facilities to strive less hard to meet the requirements of other programs.

### Specific Conditions for Participation of Hospitals

An institution, to meet the definition of a hospital, must (a) be primarily engaged in providing diagnostic and therapeutic services or rehabilitation services, (b) maintain clinical records, (c) have by-laws in effect for its medical staff, (d) have a requirement that every patient must be under the care of a physician, (e) provide 24-hour nursing service rendered or supervised by registered professional nurses, (f) have in effect a utilization review plan and (g) be licensed or approved under the applicable local law. In addition, the institution must meet certain health and safety requirements to be established by the Secretary of Health, Education, and Welfare.

These specified conditions provide a basic definition of a hospital and embody minimum requirements of safety, sanitation, and quality. As such, they are fully in accord with the established principles and objectives of professional hospital organizations. The requirement that there be by-laws in effect for the hospital's medical staff--included at the specific suggestion of representatives of the American Hospital Association--is intended to assure that the hospital's staff of physicians would be organized in the professionally acceptable manner characteristic of most hospitals. Such a requirement would encourage the fullest contribution by medical staff to the operation of the hospital and to the quality of medical services furnished by the individual staff members.

Under the bill, hospitals accredited by the Joint Commission on Accreditation of Hospitals would be conclusively presumed to meet all the statutory conditions for participation, save that for utilization review. However, in the event the Joint Commission adopts a requirement for utilization review accredited hospitals could be presumed to meet all the statutory conditions. Linking the conditions for participation to the requirements of the Joint Commission provides assurance that only professionally established conditions would have to be met by providers of health services which seek to participate in the program.

### Health and Safety Standards

Under the bill, the Secretary of HEW would have the authority to prescribe conditions in addition to those specifically listed (only, however, in the case of hospitals, to the extent that these conditions have been incorporated into the requirements of the Joint Commission on Accreditation of Hospitals) where such additional conditions are found to be necessary in the interest of the health or safety of beneficiaries. This authority is proposed because it would be inappropriate and unnecessary to include in a Federal law all of the precautions against fire hazards, contagion, etc., which should be required of institutions to make them safe. Payment for services in institutions where there are fire and health hazards could seriously undermine the efforts of State health departments and professional groups to eliminate dangerous conditions in health care institutions.

### States Could Require Higher Standards

The national minimum conditions for participation by providers of health services could vary for different areas and classes of institutions. If a State decided, for example, that all extended care facilities within its jurisdiction should satisfy higher requirements than are stipulated for use generally in all States and requested that certain specified higher requirements be applied with respect to institutions within its jurisdiction, the Secretary of HEW would have the authority to apply these State rules in the Federal program. Thus the Federal program could support the States in their efforts to improve conditions in institutions. In no event, however, could the conditions for participation of hospitals go beyond those required for accreditation by the Joint Commission on Accreditation of Hospitals.

The States would have the function of applying the requirements for participation in the Federal program to the institutions within their jurisdictions. In this way, too, the States would have the opportunity to coordinate their current efforts in appraising the quality of institutions with functions which would be performed under the proposal.

The conditions for participation were framed so that medically supervised rehabilitation facilities could qualify either as hospitals or extended care facilities. Some rehabilitation facilities are for all intents and purposes hospitals and in fact some are licensed as hospitals. Others are more like extended care facilities than hospitals in the extent of their medical supervision, staffing, and scope of service. An institution of either type, which conducts a program of rehabilitating disabled people, could participate in the program by meeting the conditions specified in the bill for a hospital or an extended care facility.

### Mental and Tuberculosis Hospitals Excluded

Under the bill, institutions providing care primarily for mental or tuberculosis patients are excluded from participation. The main reason for this exclusion is that most of these hospitals are public institutions and are supported by public funds. Nor did it seem reasonable to cover private but not public institutions. It should be kept in mind that the care provided by general hospitals to persons afflicted with mental disease or tuberculosis would be included.

### Conditions for Participation of Extended Care Facilities

To meet the definition of an "extended care facility" an institution (or a distinct part of an institution) must have an agreement with a hospital for the timely transfer of patients

and medical and other information about patients or be under common control with a participating hospital, and (a) primarily provide skilled nursing care for patients requiring planned medical or nursing care, or rehabilitation services, (b) have medical policies established (and with provision for review of these policies) by a professional group (including one or more physicians and one or more registered professional nurses), (c) have a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies, (d) have a requirement that every patient be under a physician's care and provide for another physician to be available in emergencies when the patient's physician is not available, (e) maintain clinical records, (f) provide 24-hour nursing service sufficient to meet nursing needs in accordance with the policies developed as provided in (b) and have a least one registered professional nurse employed full time, (g) provide appropriate methods and procedures for dispensing and administering drugs and biologicals, (h) have in effect a utilization review plan, and (i) be licensed or otherwise be approved as required under applicable local law. Extended care facilities must also meet such conditions essential to health and safety as may be found necessary. The requirement that an extended care facility have a transfer agreement with a hospital--for the timely transfer of patients and the timely interchange of medical and other information about patients transferred between the institutions--would help to assure the proper level of care as the patient's needs change.

These conditions describe the essential elements necessary for an institutional setting in which high quality convalescent and rehabilitative care can be furnished to patients who have passed the acute stage of their illness. The proposed program is not intended to cover services furnished in nursing homes generally, many of which are oriented not to curing or rehabilitating the patient but to giving him custodial care.

#### Requirement for Review of Utilization of Services

The utilization review plan required for participation in the program by hospitals and extended care facilities must provide for a review of admissions to the institution, length of stays, and the medical necessity for services provided as well as the efficient use of services and facilities. Such a review must be made in each case within one week following the twenty-first day of each period of continuous hospitalization, and subsequently at such intervals as may be specified in regulations. In the case of admissions to extended care facilities, the review must be made at such intervals as may be specified in regulations. In the event of an unfavorable finding the review group must notify the attending physician of its findings and provide an opportunity for consultation between the committee and the physicians.

These provisions with respect to utilization review mechanisms follow the kind of recommendation review that have been made by private study groups, State and national medical societies, and State agencies. The utilization review requirement in the bill provides that not only would hospital and extended care facility staff reviews meet the requirement but other physician review arrangements outside the hospital or extended care facility would be acceptable for purposes of the program as well. The proposal provides specifically that the reviews could be carried out by a group established by the local medical society. Furthermore, if and when the Joint Commission includes a utilization review requirement for accreditation, accreditation by the Joint Commission could be accepted by the Secretary as sufficient evidence that a hospital meets the requirements of the law.

#### Conditions for Participation of Home Health Agencies

To meet the definition of a home health agency an organization must (a) be a public agency or a nonprofit organization exempt from Federal taxation under Section 501 of the Internal Revenue Code of 1954, (b) be primarily engaged in providing skilled nursing or other therapeutic services, (c) have medical policies established by a professional group (including one or more physicians and one or more registered professional nurses) to govern these services and provide for supervision of these services by a physician or a registered professional nurse, (d) maintain clinical records, and (e) be licensed or approved under applicable local law. As in the case of hospitals and extended care facilities, home health agencies would also have to meet further conditions, to the extent these conditions are found necessary in the interest of the health and safety of the patients.

#### Home Health Services Covered

The conditions for participation of home health agencies are designed primarily to provide assurance that agencies participating in the program are basically suppliers of health services. The bill would cover visiting nurse organizations as well as agencies specifically established to provide a wide range of organized home health services. The provision of services under such agencies is now only in the initial stage of development. The services covered are based on the practices of the agencies now in existence which furnish a broad range of organized home health services which may be used as a substitute for continued hospital care. These agencies, while few and generally of recent origin, have established excellent records of operation so that it seems reasonable to expect new providers of services to adopt the pattern of organization found successful thus far. These home health service agencies offer primarily visiting nurse services but many offer other therapeutic services.



## PAYMENT TO PROVIDERS

Under the bill, the provisions for paying for covered services follow the recommendations of the American Hospital Association--that is, payments to providers of service would be made on the basis of the reasonable cost of services furnished. The Secretary would be authorized to develop a method or methods of determining costs and to provide for payment on a per diem, per unit, per capita, or other basis, as most appropriate under the circumstances. The principles for reimbursing hospitals developed by the American Hospital Association provide a basis for determining how costs should be computed. However, since the elements of cost are, to some extent, different for different types of providers of health services--for example, hospitals as contrasted to extended care facilities--a number of alternative methods of computing costs are permitted so that variations in practices may be taken into account. In computing reimbursement on a "reasonable cost" basis, the program would be following practices with respect to reasonable cost reimbursement already well established and accepted by hospitals in their dealings with other Federal and State programs and with Blue Cross.

## EXCLUSION OF FEDERAL HOSPITALS

No payment would be made to a Federal hospital, except for emergency services, unless it is providing services to the public generally as a community hospital--a rare situation, but the exclusion of such institutions would be a hardship to beneficiaries in the localities involved. Also, payment would not be made to any provider for services it is obligated to render at public expense under Federal law or contract. The purpose of this exclusion is to assure that Federal hospitals would not be used to furnish care under the program as well as to avoid payment for services which are furnished under other government programs to veterans, military personnel, etc. Furthermore, this exclusion would have the effect of reducing future need for Federal hospitals for veterans and retired members of the armed forces and place more emphasis on the use of voluntary hospitals for their care.

## EMERGENCY SERVICES

Payment could be made to nonparticipating hospitals for emergency inpatient hospital services--or emergency outpatient diagnostic service--if the hospital agrees not to make any charges to the beneficiary with respect to the emergency services for which payment

is provided. The proposal does not cover use of the emergency ward for outpatient purposes except where the diagnostic service provision, subject to a deductible, applies.

#### AGREEMENTS BY PROVIDERS

Any eligible provider may participate in the proposed program if it files an agreement not to charge any beneficiary for covered services and to make adequate provision for refund of erroneous charges. Of course, a provider could bill a beneficiary for the amount of the deductible, and for the portion of the charge for expensive accommodations or services supplied at the patient's request and not paid for under the proposal.

An agreement may be terminated by either the provider of services or the Secretary of HEW. The Secretary may terminate an agreement only if the provider (a) does not comply with the provisions of law or the agreement, (b) is no longer eligible to participate, or (c) fails to provide data to determine benefit eligibility or costs of services, or refuses access to financial records for verification of bills.

#### ADMINISTRATION

As in the case of other benefits under the social security system, over-all responsibility for administration of the hospital and related benefits would rest with the Secretary of Health, Education, and Welfare. Similar responsibility for railroad retirement annuitants rests with the Railroad Retirement Board. Agreements by hospitals and other providers with the Secretary would be made on behalf of both the Secretary and the Board.

The bill provides for the establishment of an Advisory Council to advise the Secretary on administrative policy matters. The Advisory Council, appointed by the Secretary, would consist of a chairman and 15 members who are not otherwise employees of the Federal Government. To assure representation of the health professions, the membership of the Advisory Council would include persons outstanding in hospital or other health activities.

The Secretary would also be required to consult with appropriate State agencies, national and State associations of providers of services, and recognized national accrediting bodies. These efforts would be especially oriented to the development of policies, operational procedures and administrative arrangements of mutual satisfaction to all parties interested in the program. This consultation at the local and national level would also provide additional assurance that varying conditions of local and national significance are taken into account.

## ROLE OF THE STATES

Under the bill the Secretary is authorized to use State agencies to perform certain administrative functions. It is expected that the Secretary would exercise this authority fully, and it is believed that all States would be willing and able to assume these responsibilities. State agencies would be used in:

- a. determining whether and certifying to the Secretary that a provider meets conditions for participation in the program;
- b. rendering consultative services to providers to assist them in meeting the conditions for participation, in establishing and maintaining necessary fiscal records and in providing information necessary to derive operating costs so as to determine amounts to be paid for the provider's services;
- c. rendering consultative services to providers and medical societies to assist in the establishment and testing of utilization review plans and procedures.

State agencies would be reimbursed for the costs of activities they perform in the program. As in the cooperative arrangements with State agencies in the social security disability program, reimbursement to State agencies for hospital insurance benefits activities would meet the agency's related costs of administrative overhead as well as of staff. In recognition of the need for coordination of the various programs in the States that have to do with payment for health care, quality of care, and the distribution of health services and facilities, the Federal Government would pay a fair share of the State agency's costs attributable to planning and other efforts directed toward the coordination of the agency's activities under the proposed program.

What is contemplated in administration of the insurance program is a Federal-State relationship under which each governmental entity performs those functions for which it is best equipped and most appropriately suited. State governments license health facilities and State public health authorities generally inspect these facilities to determine whether they are conforming with the requirements of the State licensure law. In addition, State programs purchase care from providers of health services. On the basis of experience and function, State agencies would assist the Federal Government in determining which providers of health services conform to prescribed conditions for participation. Furthermore, where an institution or organization that has not yet qualified needs consultative services in order to determine what

steps may be appropriately taken to permit qualification, such consultative services would be furnished by the State health or other appropriate State agency. Other types of consultative services closely related to conditions of the hospital benefits program or similarly related to State programs and requirements should logically be provided for or coordinated in the State agency. There may, of course, be situations where a State is unwilling or unable to perform some or all of these certifications and consultative services. In any such situation, the Secretary will have to make other provisions to carry on these activities.

### ROLE OF PRIVATE ORGANIZATIONS

The bill would provide the opportunity for considerable participation by private organizations in the administration of the program. Groups of providers, or associations of providers on behalf of their members, would be permitted to designate a private organization to act as an intermediary between themselves and the Federal Government. The designated organization would determine the amounts of payments due upon presentation of provider bills and make such payments. In addition, such organizations could be authorized, to the extent the Secretary considers it advantageous, to perform other related functions such as auditing provider records and assisting in the application of utilization safeguards. Such activities are likely to prove advantageous where private organizations have developed experience and skill in these activities. The Government would provide advances of funds to such organizations for purposes of benefit payments and as a working fund for administrative expenses, subject to account and settlement on a cost-incurred basis.

The principle advantage hospitals and other providers of services would find in an arrangement of this sort would be that the policies and procedures of the Federal program would be applied by the same private organizations which administer the existing health insurance programs from which providers now receive payments. The participation of Blue Cross plans and similar third-party organizations would have advantages that go beyond the benefits derived from their experience in dealing with various types of providers of services. Such private organizations, serving as intermediaries between the Government and the providers, would reduce the concern expressed by some people that the Federal Government might try to interfere in hospital affairs.

### COMPLEMENTARY PRIVATE INSURANCE

A guiding principle in the formulation of the program is the desirability of encouraging private insurance to play the same

complementary role to hospital insurance for the aged under social security that it has played under the retirement, death, and disability benefit provisions of the social security program. It was in part because of this principle that the decision was made to provide a program oriented toward meeting only the major costs of hospitalization. It was assumed that with social security providing basic protection of this form beneficiaries would obtain additional private supplementary protection and private carriers would seek to provide such protection. While the hospital insurance protection that would be provided by social security would be significant and substantial, it would not cover all of the health costs that are capable of being insured against.

The bill, therefore, authorizes the creation of nonprofit associations of private insurers to develop and offer for sale to aged persons health benefit plans covering costs not met under the Government program--specifically plans covering most of the costs of physicians' services. These activities of private insurers would be exempt from Federal and State anti-trust laws.

#### FINANCING

The hospital insurance program would be financed by allocating 0.60 percent of taxable wages paid in 1966; 0.76 percent of taxable wages paid in 1967 and 1968; and 0.90 percent of taxable wages paid thereafter, to a ~~special hospital insurance trust fund~~ that would be established for the program. Allocations of 0.45, 0.57 and 0.675 percent of self-employment income taxable under social security would be made, respectively, in the taxable years 1966, 1967-68, and 1969 and thereafter.

The following examples illustrate the cost of the hospital insurance program to the employee in 1969 and thereafter: A worker earning \$3,000 would pay \$13.50 a year; one earning \$4,800 would pay \$21.60 a year; and a worker earning \$5,600 a year, the maximum earnings subject to contributions under the bill, would pay \$25.20 a year.

The cost of the benefits for persons not insured under the social security or railroad retirement system would be borne by general revenue of the Treasury.

#### Separate Trust Fund

Under the proposal there would be a separate trust fund for the hospital insurance program in addition to the present old-age and survivors insurance trust fund and the disability insurance trust fund. Under the proposed law, hospital insurance benefits could be paid only from the hospital insurance trust fund, just as under present law disability insurance benefit can be paid only from the disability insurance trust fund.

The income to the hospital insurance trust fund is estimated actuarially to meet the costs into the indefinite future. Estimated contribution income to the new trust fund for 1967 (the first year of the program's full operation) would total \$1.98 billion and estimated expenses \$1.78 billion. Payments made on behalf of persons who are not eligible for social security or railroad retirement benefits would be made from the trust fund but the fund would be fully reimbursed for all costs involved in such payments from general revenue of the Treasury.

#### EFFECTIVE DATES

Benefits would be payable for covered hospital and related health services furnished beginning July 1, 1966, except for post-hospital extended care, for which the effective date would be January 1, 1967. The allocations to the hospital insurance fund from social security contributions would begin in 1966. The allocation for 1966 would enable a fund to be built up before benefits become payable.